Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA MEDICAL CENTER
4301 VISTA RD
PASADENA TX 77504-2117

Respondent Name
AMERICAN HOME ASSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-05-1748-01

MFDR Date Received
October 22, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "it is appropriate to use the 'Ingenix Range' of 213.3% to 290% of the Medicare rate in effect at the time of the procedure plus 31% in determining a fair and reasonable reimbursement in this case. . . . Further, or in the alternative . . . the amount in the 2008 Outpatient Hospital Facility Fee Guideline, with some adjustment, is fair and reasonable in this case. . . . the Outpatient Medicare reimbursement should use the same factors of 213.3% to 290% plus 31% unless and until the 200% PAF produces a higher reimbursement (as in later years)."

Amount in Dispute: $13,009.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "I am filing the TWCC-60 Form on behalf of the above-referenced insurance carrier in response to the Requestor's dispute for fee reimbursement for date of service of November 7, 2003. As a result, no further reimbursement was recommended towards the amount in dispute of $13,009.39."

Response Submitted by: Hoffman Kelley LLP, 400 West 15th Street, Suite 1520, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 7, 2003	Outpatient Hospital Services	$13,009.39	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding health care reimbursement policies and

guidelines.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 360 – ALLOWANCE FOR THIS PROCEDURE WAS MADE AT THE 'FAIR AND REASONABLE' AMOUNT FOR THIS GEOGRAPHICAL AREA.
   - 426 – REIMBURSED TO FAIR AND REASONABLE.
   - M – Reduced to Fair and Reasonable.
   - 350 – BASED ON THE SUBMITTED DOCUMENTATION FROM THE PROVIDER, WE RECOMMEND AN ADDITIONAL ALLOWANCE BE MADE.
   - 859 – Re-eval letter of explanation will be mailed under separate mailout
   - 920 – COMPLEX BILL - REVIEWED BY MEDICAL COST ANALYSIS TEAM – UD/JW
   - F – FEE SCHEDULE MAR REDUCTION
   - S – SUPPLEMENTAL PAYMENT

Findings

1. The requestor's position statement asserts that "There is a possibility that reimbursement for the services provided may be covered by a contract that Provider had with Focus Healthcare Management, Inc." Review of the submitted information finds no documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to outpatient hospital services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "it is appropriate to use the 'Ingenix Range' of 213.3% to 290% of the Medicare rate in effect at the time of the procedure plus 31% in determining a fair and reasonable reimbursement in this case."
   - No documentation was submitted to support the Medicare rate calculation for the services in dispute.
   - The requestor did not explain or provide documentation to support how a specific payment adjustment factor amount should be selected from within the proposed range.
   - The Division has previously found that Medicare patients are of an equivalent standard of living to workers' compensation patients (22 *Texas Register* 6284); however, Texas Labor Code §413.011(b) requires that "In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d). . . . This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services."
   - The requestor's proposed payment adjustment factor range of "213.3% to 290% of the Medicare rate in effect at the time of the procedure plus 31%" is not based on factors developed by the Centers for Medicare and Medicaid Services (CMS). This range is based on recommendations made by Ingenix, Inc. "a professional firm specializing in actuarial and health care information services" contracted by the Texas Workers' Compensation Commission (TWCC) in 2001 to assist "in developing new fee guidelines to address fees for health care services provided in inpatient and outpatient facilities and ASCs." (29 *Texas Register* 4194, April 30, 2004); however, the Ingenix recommended range of 213.3% to 290% was developed as a payment adjustment factor for ambulatory surgical center (ASC) services, not for outpatient hospital services. (29 *Texas Register* 4196, April 30, 2004) No information was found to support that the Ingenix recommended range of 213.3% to 290% for ASC services would produce a fair and reasonable rate of reimbursement when applied to the Medicare rate for outpatient hospital services.
   - The requestor proposes that "it is appropriate to use the 'Ingenix Range' of 213.3% to 290% of the

Medicare rate in effect at the time of the procedure plus 31% in determining a fair and reasonable reimbursement in this case." In support of this, the requestor states that "in September of 2008 the DWC determined that a 31% increase in the amount paid to ASC's would be a fair and reasonable reimbursement for hospital outpatient."

- No documentation was found to support that the DWC determined that a 31% increase in the amount paid to ASCs would be a fair and reasonable reimbursement for outpatient hospital services.
- The Division has previously found that "The reimbursement for ASCs is currently based on the ASC group classifications model, and the ASC payment adjustment factor has no direct relationship to the APC reimbursement payment adjustment factor." (33 *Texas Register* 415, January 11, 2008) The requestor has not demonstrated or supported an identifiable relationship between the reimbursement amounts under Medicare's ASC payment model and the amounts reimbursed for the same or similar services under Medicare's APC payment system for outpatient hospital services. Therefore, a reimbursement amount based on a payment adjustment factor developed for ASC services cannot be favorably considered for outpatient hospital services when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor has failed to demonstrate or support that a 31% increase in the Ingenix proposed payment adjustment factor range of 213.3% to 290% for ASC services would produce a fair and reasonable reimbursement for outpatient hospital services.
- The requestor proposes an alternative fair and reasonable reimbursement methodology, stating that "Further, or in the alternative . . . the amount in the 2008 Outpatient Hospital Facility Fee Guideline, with some adjustment, is fair and reasonable in this case."
- The provisions of the 2008 *Hospital Facility Fee Guideline—Outpatient*, at 28 Texas Administrative Code §134.403, adopted to be effective March 1, 2008, 33 *Texas Register* 400, were not applicable or effective at the time of the disputed date of service.
- The requestor asserts that "The 2003-2007 data considered by the DWC in developing a fair and reasonable reimbursement for outpatient services is relevant because the date of service in this case is 11/07/2003. However, as noted above, the reimbursement rate for hospital outpatient services should be higher than ASC reimbursement; therefore, the Outpatient Medicare reimbursement should use the same factors of 213.3% to 290% plus 31% unless and until the 200% PAF produces a higher reimbursement (as in later years)."
- The requestor has not demonstrated or supported that the payment adjustment factor range recommended for Medicare's ASC payment model, even when adjusted again by 31%, would produce a fair and reasonable rate when applied to reimbursements under the APC payment system for outpatient hospital services. The requestor has not established or supported an identifiable relationship between the two payment systems. During the time period of the services in this dispute, the Division had found that "Medicare has not significantly revised ASC cost inputs since 1994. . . . Medicare reimbursements for ASC services are well below the range of payments made by most commercial payers for those services." (29 *Texas Register* 4187, April 30, 2004) Moreover, as stated above, the Division has previously found that "The reimbursement for ASCs is currently based on the ASC group classifications model, and the ASC payment adjustment factor has no direct relationship to the APC reimbursement payment adjustment factor." (33 *Texas Register* 415, January 11, 2008) Therefore, the Division finds that substituting the proposed 213.3% to 290% payment adjustment factor range (as recommended by Ingenix for ASC services) plus 31% applied to the payment methodology set forth in the 2008 *Hospital Facility Fee Guideline—Outpatient* (in lieu of the 2008 payment adjustment factor of 200% found in the guideline), cannot be favorably considered when the requestor has failed to demonstrate or support that the proposed adjustment factor would produce a fair and reasonable reimbursement for outpatient hospital services performed on the disputed date of service, and no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- In support of the requested reimbursement, the requestor submitted redacted explanations of benefits, and selected portions of EOBs, from various sample insurance carriers. However, the requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the sample EOBs are for services that are substantially similar to the services in dispute. The carriers' reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.
- The requestor did not support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that the requested reimbursement would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division further concludes that the requestor has failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	December 12, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.